Hopewell Medical Center
815 W Poythress Street
Hopewell, Virginia 23860
(804) 458-8557

Colonial Heights Medical Center
3512 Boulevard
Colonial Heights, VA 23834
(804) 520-1110

PLEASE PRINT CLEARLY

Date _______________

Full Legal Name: ________________________ **SS#:** ________________________ **Date of Birth:** _____________

Race (circle one): Caucasian African-American Asian Hispanic American-Indian Native Hawaiian Other

Ethnicity (circle one): Hispanic Non-Hispanic **Preferred Language (circle one):** English Other__________

Marital Status (circle one): Single Married Divorced Widowed **Sex:** M F

Email: _______________________________ **Preferred Pharmacy:** _______________________________

Mailing Address:

____

____

Home #: ______________________________

Cell Phone #: __________________________

Work #: _______________________________

Street Address:

____

____

Emergency Contact:

Name: _________________________________

Phone #: _______________________________

Employment Status (circle one): Full-Time Part-Time Self-Employed Retired Not Employed

Patient or Guardian's Employer:

Business: ____

Address: ____

____

Primary Insurance: ________________________
Policy #: _________________________________
Subscriber's Name: ________________________
Subscriber's SS#: _________________________
Subscriber's DOB: _________________________

Supplemental Insurance: _____________________
Policy #: __________________________________
Subscriber's Name: _________________________
Subscriber's SS#: __________________________
Subscriber's DOB: __________________________

HOPEWELL MEDICAL CENTER
815 WEST POYTHRESS STREET
HOPEWELL, VIRGINIA 23860
TELEPHONE 804-458-8557

COLONIAL HEIGHTS MEDICAL CENTER
3512 BOULEVARD
COLONIAL HEIGHTS, VA 23834
TELEPHONE 804-520-1110

Date:
Name:

PRESCRIPTION REFILL POLICY

1. For Prescription refills, we respectfully ask that you allow us **forty-eight hours (48)** to fill all prescriptions.
2. Please call between the hours of 9:00 a.m. and 4:00 p.m., Monday through Friday.
3. Prescriptions for narcotics and other scheduled drugs will not be filled after office hours or on weekends. Please remember to call in advance so we can assist you in a timely manner.
4. If you have lost or misplaced your written prescription there will be a charge of $10.00 to rewrite or call in the prescription. This is payable before we process the prescription.
5. **Refills after 11:00 a.m. Friday <u>WILL NOT BE WORKED ON UNTIL MONDAY.</u>**

______________________________	______________________________
Patient **or** Guardian Signature	Date
Witness (STAFF ONLY)	Date

Patient's Name: «FirstName» «LastName»

Past Medical History
(Check all that apply)

__Headaches __Prostate Disease __High Triglycerides __Ulcer
__Shortness of Breath __Bowel Irregularity __Chronic Rashes __Gout
__Heart Palpitations __Sexual/Menstrual Dysf __Rheumatic Fever __Nervousness
__Heart Murmur __Venereal Disease __Diabetes __Depression
__Chest Pain __Hepatitis __High Blood Pressure __Pneumonia
__Dizziness/Fainting __Anemia __High Cholesterol __Bronchitis
__Allergies/Hay Fever __Arthritis __Gallbladder Disease __Asthma

Date of Immunizations

__________Mumps __________Measles _________Rubella _________Scarlet Fever
__________Polio __________Diphtheria _________Tetanus

Hospitalization or Surgery

Reason:	Date:	Reason:	Date:

Drug Allergies

____
____

Family History

	Father	Mother	Siblings	Children
Living/Deceased				
Age				
Heart Disease				
High Bld. Pressure				
Stroke				
Cancer				
Glaucoma				
Diabetes				
Epilepsy/Conv.				
Bleeding Disorder				
Kidney Disease				
Thyroid Disease				
Mental Illness				
Arthritis				

Habits

Smoke Now? _______ Coffee: Cups daily?_______
Packs Daily? _______ Other Caffeine? _______
Ever Smoked? _______ Exercise Routine? _______
How Long? _______ Sleep Patterns? _______
When Stopped? _______ Fat Intake? _______
Alcohol: Amount_______ Salt Intake? _______
Type______________________

Women Only

Menstruation: First at Age:_________________
________days between each period.
Lasts _______ days. Discomfort: ____________
Last Period_____ light, moderate, heavy
Last Pap Smear________ Breast Exam________
Pregnant________Planning Total #__________
Full Term Delivery_____# of living child._____

Contact with blood/body fluids at work?_____________ Type of Birth Control______________________
Illicit Drug Use? ___________________________________
Medications currently being taken (prescription and non-prescription):______________________________
____

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AUTHORIZATION TO DISCUSS & RELEASE CONFIDENTIAL PATIENT INFORMATION

I, ____________________________________

hereby authorize Appomattox River Medical LLC to discuss my medical and/or financial information with the following person and/or persons:
<u>*This includes, but not limited to, picking up prescriptions, samples, excuses, or any other documents left for pick up if patient is unable</u>

Name	Relationship	DOB
______________________________	___________________________	___________________________
______________________________	___________________________	___________________________
______________________________	___________________________	___________________________
______________________________	___________________________	_________________

This consent is valid until such time as I provide Appomattox River Medical LLC written revocation of it.

If we are unable to reach you in person for any reason (labs, referrals, appointments, prescriptions, & etc.):
Do we have your permission to leave a message on your voice recorder?

☐ YES Phone Number (to leave message on) ______________________________
☐ NO

____
Signature

____
Date

____
Witness (STAFF ONLY)

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AUTHORIZATION TO TREAT & RELEASE CLINICAL INFORMATION

I, _________________________ , hereby authorize Appomattox River Medical LLC to perform a medical examination and evaluation on myself and to release any and all medical/non medical information to any person or persons which would need access to my information for continuance of my medical care. My information may be sent to referring physicians; hospitals; physical therapists; durable medical equipment vendors; pharmacies; and any other health care professional, and to such insurance companies, organizations and agencies that may be concerned with the payment of medical services provided to the patient. I further authorize Appomattox River Medical LLC to obtain copies of my medical records and any test results from any source including health care providers, hospitals, insurance carriers, employers, pharmacies (including VA prescription monitoring program).

____
Signature

____
Date

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TO ALL PATIENTS:

Proof of insurance is required at time of registration. If unavailable, payment is expected at the time services are rendered or patient is expected to re-schedule. Patients are responsible for co-payments, deductibles, co-insurance and any non-covered services deemed your responsibility by your insurance carrier. Remember: The medical services rendered are your responsibility, they are charged to the patient and not to the insurance company. You, the patient are responsible for payments to the doctor. A health insurance policy is a contract between you (as the subscriber) and your insurance company. We bill any commercial insurance policies. The patient is responsible for any charges not covered or any balances not paid by the insurance company.

The undersigned hereby authorizes Appomattox River Medical, LLC to release my medical records and information to insurance companies, organizations or agencies necessary to process insurance claims concerned with the payment of medical services provided to the patient. I authorize that all insurance benefits due for medical services rendered to the patient be paid directly to Appomattox River Medical, LLC.

Failure to keep any appointments without a 24 hour notification will result in a $30.00 charge to your account. This will not be paid by your insurance company. A monthly $3.00 handling charge or 1.5% finance charge, whichever is greater, will be added to every account after thirty days and every month thereafter until the account is paid in full. Any collection expenses incurred ie, court costs and attorney fees of 33.33% or more become the responsibility of the patient and will be added to any amounts due. All returned checks are subject to a $35.00 returned check charge.

We appreciate our patients who have kept their account paid in full and look forward to serving you in the future.

Guardian/Guarantor expressly guarantees prompt payment and terms for the above charges for a minor child or an adult child (over the age of (18) eighteen) until the Guardian/Guarantor removes this responsibility in writing.

I have read and understand the above conditions:

____
Patient's Name

____
Patient Signature: Date

____
Guardian/Guarantor Signature (if a minor) Date

____
Witness (STAFF ONLY): Date

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A law was enacted in Virginia in 1989 which authorizes health care providers to test their patients for HIV antibodies when the health care provider is exposed to the body fluids of a patient in a manner which may, according to certain medical authority, transmit human immunodeficiency virus (HIV), the virus that causes acquired immunodeficiency syndrome (AIDS) and related disorders. Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing, and to have consented to the release of the test results to the health care provider who may have been exposed. However, if such exposure occurs, you will be informed before any of your blood is tested for HIV antibodies pursuant to this provision, the testing will be explained to you, and you will be given the opportunity to any questions you might have.

The law also provides that if you should be exposed to the body fluids of a health care provider in a manner which may, according to certain medical authority, transmit HIV, the health care provider is deemed to have consented to such testing and to the release of the test results to you.

I have read and understand the above “Notice of deemed consent to HIV blood testing”.

______________________________	______________________________
Date	Patient’s Signature (or parent or guardian’s signature, if minor)

Appomattox River Medical, LLC.

NOTICE OF PRIVACY PRACTICES
Effective August, 2016

I have received a copy of the Notice of Privacy Practices. I have read and understand these privacy practices as they apply to my health information.

Name (print): ____

Patient **or** Guardian Signature: _______________________________________

Date: _______________

Witness: ____
(STAFF ONLY)

NOTICE OF PRIVACY PRACTICES

Effective August, 2016

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND/OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEAST REVIEW IT CAREFULLY.

This is our promise to you, our patients. Your information is important and confidential. Our ethics and policies require that your information be held in strict confidence.

Introduction

Appomattox River Medical, LLC., is required by law to maintain the privacy of your protected health information, to provide you with notice regarding our legal duties and privacy practices with respect to protected health information, and to notify you following a breach of your unsecured protected health information.

We maintain protocols to ensure the security and confidentiality of your personal information. We have physical security in our building, passwords to protect databases, compliance audits, and virus/intrusion detection software. Within our practice, access to your information is limited to those who need it to perform their jobs.

At the offices of Appomattox River Medical, LLC., we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective August, 2016, and applies to all protected health information as defined by federal regulations.

A copy of this notice is available on our website; you can also request that a copy be sent to you by email. We will also provide copies of this Notice to you, upon request, anytime you visit our office. A copy is also on display in our office.

We are required to abide by the terms of this notice. We reserve the right to change the terms of this notice and to make new terms effective for all protected health information we maintain. Any revised notice will be available to you as we described above.

Understanding Your Health Record

Each time you visit Appomattox River Medical, LLC., a record of your visit is made. Typically this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment;
- Means of communication among the many health professionals who contribute to your care;
- Legal document describing the care you received;
- Means by which you or a third-party payer can verify that services billed were actually provided;
- Tool in education for health professionals;
- Source of data for medical research;
- Source of information for public health officials charged to improve the health of the state and nation;
- Source of data for our planning and marketing; and,
- Tool by which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy; better understand who, what, when, where, and why others may access your health information; and, make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Appomattox River Medical, LLC., the information in it belongs to you. You have the right to:

- Obtain a copy of this Notice of Privacy Practices upon request, including a paper or electronic copy as requested by you;
- Request access to inspect and a copy of your health record, including and electronic copy, as provided by 45 CFR 164.524 (reasonable copy fees apply in accordance with state law);
- Request an amendment to correct or supplement your health record as provided by 45 CFR 164.526;
- Request an accounting of disclosures of your health information for the prior six years, except disclosures for treatment, payment, or health care operations, or those made subject to your authorization, as provided by 45 CFR 164.528;
- Request alternative means and/or locations to receive confidential communications of your health information as provided by 45CFR 164.522(a).

Appomattox River Medical, LLC., is not required to make all amendments requested or to implement all restrictions requested, particularly in cases that will affect your care, but we will promptly advise you if we will not do so. Appomattox River Medical, LLC., must agree to restrict disclosure of your protected health information to a health plan if the purpose of the disclosure would be to carry out payment or health care operations and you and/or someone on your behalf, other than your health plan, paid for this health care in full. Additionally, Appomattox River Medical, LLC., will accommodate all reasonable requests to receive confidential communications by alternative means and/or at alternative locations.

To exercise any of the rights described above, please ask any Appomattox River Medical, LLC., employee. If they can't help you directly, they'll direct you to a person who can. You can also contact Beverly Balint, our practice Privacy Officer, at (804) 458-8557. She may ask that you put any request in writing and provide you with the address and other relevant information.

Our Responsibilities

Our Practice is required to:

- Maintain the privacy of your health information;
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Timely notify you if we are unable to agree to a requested access, restriction of your medical records;
- Accommodate reasonable requests you may have to communicate your health information; and
- Promptly notify you of any breach of your protected health information.

We typically use/disclose your health information for treatment, payment, and/or health care operations.
Examples of Disclosures for Treatment, Payment, and Health Operations we will use your health information for treatment.

We may provide medical information about you to health care providers, our practice personnel, or third parties who are involved in the provision, management, or coordination of your care.
For Example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your medical information will be shared among health care professionals involved in your care.
We will also provide your other physician(s) or subsequent health care provider(s) (when applicable) with copies of various reports that should assist them in treating you.

We will use your health information for payment.
We may disclose your information so that we can collect or make payment for the health care services you receive.
For Example: If you participate in a health insurance plan, we will disclose necessary information to that plan to obtain payment for your care.

We will use your health information for regular health care operations.
We may disclose your health information for our routine operations. These uses are necessary for certain administrative, financial, legal, and quality improvement activities that are necessary to run our practice and support the core functions.
For Example: Members of our quality improvement team may use the information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide and to reduce health care costs.
Other uses/disclosures:

- Appointment Reminders
  We may use/disclose medical information to provide appointment reminders (e.g., contacting you at the phone number you have provided to us and leaving a message as an appointment reminder).
- Decedents
  Consistent with applicable law, we may disclose health information to a coroner, medical examiner, or funeral director.
- Workers Compensation
  We may disclose health information to the extent authorized by and necessary to comply with laws relating to workers compensation or other similar programs established by law.
- Public Health
  We may, in accordance with applicable law, disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- Research
  We may disclose information to researchers when their research has been approved and the researcher has obtained a required waiver for the Institutional Review Board/Privacy Board, who has reviewed the research proposal.
- Organ Procurement Organizations

Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation or organs for the purpose of donation and transplant.

- As Required By Law
  We may disclose health information as required by law. This may include reporting a crime, responding to a court order, grand jury subpoena, warrant, discovery request, or other legal process, or complying with health oversight activities, such as audits, investigations, and inspections necessary to ensure compliance with government regulations and civil rights laws.
- Specialized Government Functions
  We may disclose health information for military and veteran's affairs or national security and intelligence activities.
- Business Associates

There are some services provided in our organization through contacts with business associates. Some examples are laboratory transcription services we may use. Due to the nature of business associates' services, they must receive your health information in order to perform jobs we have asked them to do. To protect your health information, however, when these services are contracted we require the business associate to appropriately safeguard your information

- Practice Information

We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you (for example, to notify you of any new tests or services we may be offering).

- Food and Drug Administration (FDA)

We may disclose to the FDA health information relative to adverse events with respect to food, supplements, or other regulated products as well as product defects or post marketing surveillance information to enable product recalls, repairs, or replacement.

- Personal Representative

We may communicate your protected health information with your personal representative (person legally responsible for your care and authorized to act on your behalf in making decisions related to your health care).

- To Avert a Serious Threat to Health/Safety

We may disclose your information when we believe in good faith that this is necessary to prevent a serious threat to your safety or that of another person. This may include cases of abuse, neglect, or domestic violence.

- To demonstrate HIPPA Compliance
  Disclosures may be made to the Secretary of Health and Human Services to demonstrate HIPPA compliance.

You may choose to allow us to share your protected health information:

- Disaster Relief
- You may agree that we may disclose health information about you to an organization assisting in a disaster relief effort.
  Communication with Family

You may agree that we may disclose to a family member or close personal friend health information relevant to that person's involvement in your care or payment related to your care. Way may notify these individuals of your location and general condition.

If you are not able to tell us your preference, for example if you are unconscious, we may share your relevant health information with family members and/or disaster relief personnel if we believe it is in your best interest.

We will not use/disclose your protected health information without your prior written authorization for the following purposes/activities:

- Marketing Activities;
- Sale of protected health information;
- Most uses/disclosures of psychotherapy notes, where applicable.

We will not use or disclose your health information in a manner other than as generally described above without your prior written authorization, which you may revoke as provided by 45 CFR 164.508(b)(5), except to the extent that action has already been taken in reliance on your prior authorization.

For More Information or to Report a Problem

If you have questions and/or would like additional information, you may contact our practice's Privacy Officer, Beverly Balint, at (804) 458-8557, or with the Office for Civil Rights (OCR), U.S. Department of Health and Human Services (OCR).

There will be no retaliation for filing a complaint with either our practice or the OCR. The address for the OCR is as follows:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
1-877-696-6775

Alternatively, you can file a complaint with OCR by visiting www.hhs.gov/ocr/privacy/hippa/complaints/.